NEW YORK STATE
DEPARTMENT OF HEALTH
OFFICE OF THE MEDICAID INSPECTOR GENERAL

REVIEW OF NEW YORK SERVICE NETWORK, INC. CLAIMS FOR OUTPATIENT CHEMICAL DEPENDENCE SERVICES PAID FROM MAY 1, 2003 – DECEMBER 31, 2007

FINAL AUDIT REPORT

James G. Sheehan
Medicaid Inspector General

November 23, 2010

STATE OF NEW YORK
OFFICE OF THE MEDICAID INSPECTOR GENERAL
90 Church Street, 14th Floor
New York, NY 10007

DAVID A. PATERSON
GOVERNOR

JAMES G. SHEEHAN
MEDICAID INSPECTOR GENERAL

November 23, 2010

Mr. Fred Middleton
Executive Director
New York Service Network, Inc.
198 Foster Ave
Brooklyn, NY 11230

Re: Final Audit Report
Audit #: 09-2553

Dear Mr. Middleton:

Enclosed is the Office of the Medicaid Inspector General (OMIG) final audit report entitled "Review of New York Service Network, Inc." (New York Service Network) paid claims for outpatient chemical dependence services covering the period May 1, 2003 through December 31, 2007.

In the attached final report, the OMIG has detailed our objectives and scope, procedures, laws, regulations, rules and policies, sampling technique, findings, provider rights, and statistical analysis.

The OMIG has attached the sample detail for the paid claims determined to be in error. This audit report incorporates consideration of any additional documentation and information presented in response to the draft report dated August 3, 2010. The mean point estimate overpaid is $2,589,991. The lower confidence limit of the amount overpaid is $2,183,945. We are 90% certain that the actual amount of the overpayment is greater than the lower confidence limit. This audit may be settled through repayment of the lower confidence limit of $2,183,945.

If New York Service Network has any questions or comments concerning this report, please contact Thomas Barone at (518) 486-7200 or through email at Thomas.Barone@omig.ny.gov. Please refer to report number 09-2553 in all correspondence.

Sincerely,

Craig C. Francis, Director
Division of Medicaid Audit, New York City
Office of the Medicaid Inspector General

Enclosure

CERTIFIED MAIL #7007 1490 0004 1293 6216
RETURN RECEIPT REQUESTED

CC: Douglas M. Nadjari, Esq.
Jacobson Goldberg & Kulb, LLP
585 Stewart Avenue, Suite 720
Garden City, New York 11530

OFFICE OF THE MEDICAID INSPECTOR GENERAL

www.omig.ny.gov

The mission of the Office of the Medicaid Inspector General (OMIG), as mandated by New York Public Health Law § 31 is to preserve the integrity of the New York State Medicaid program by preventing and detecting fraudulent, abusive and wasteful practices within the Medicaid program and recovering improperly expended Medicaid funds.

DIVISION OF MEDICAID AUDIT

The Division of Medicaid Audit professional staff conducts audits and reviews of Medicaid providers to ensure compliance and program requirements and, where necessary, to recover overpayments. These activities are done to monitor the cost-effective delivery of Medicaid services for prudent stewardship of scarce dollars; to ensure the required involvement of professionals in planning care to program beneficiaries; safeguard the quality of care, medical necessity and appropriateness of Medicaid services provided; and, to reduce the potential for fraud, waste and abuse.

DIVISION OF MEDICAID INVESTIGATIONS

The Division of Medicaid Investigations (DMI) investigates potential instances of fraud, waste, and abuse in the Medicaid program. DMI deters improper behavior by inserting covert and overt investigators into all aspects of the program, scrutinizing provider billing and services, and cooperating with other agencies to enhance enforcement opportunities. Disreputable providers are removed from the program or prevented from enrolling. Recipients abusing the system are not removed from this safety net, but their access to services is examined and restricted, as appropriate. DMI maximizes cost savings, recoveries, penalties, and improves the quality of care for the state's most vulnerable population.

DIVISION OF TECHNOLOGY AND BUSINESS AUTOMATION

The Division of Technology and Business Automation will continue to support the data needs for the OMIG in the form of audit and investigative support, data mining and analysis, system match and recovery, through the use of commercial data mining products and procurement of expert service consultants.

OFFICE OF COUNSEL TO THE MEDICAID INSPECTOR GENERAL

The Office of Counsel to the Medicaid Inspector General promotes the OMIG's overall statutory mission through timely, accurate and persuasive legal advocacy and counsel.

EXECUTIVE SUMMARY

BACKGROUND

Pursuant to Title XIX of the Social Security Act, the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The federal and state governments jointly fund and administer the Medicaid program. In New York State, the Department of Health (DOH) administers the Medicaid program. As part of this responsibility, the OMIG conducts audits and reviews of various providers of Medicaid reimbursable services, equipment and supplies. These audits and reviews are directed at ensuring provider compliance with applicable laws, regulations, rules and policies of the Medicaid program as set forth by the Departments of Health and Mental Hygiene [Titles 10, 14 and 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York] and the Medicaid Provider Manuals.

Outpatient chemical dependence services are provided in either hospital-based or free-standing settings. Regardless of the setting in which they are provided, these services must be furnished in one of two distinct programs: an outpatient chemical dependence clinic program or an outpatient chemical dependence rehabilitation program. The purpose of outpatient programs for individuals with a diagnosis of chemical dependence is to provide medical evaluation, clinical care management, clinical services, and rehabilitation services. The specific standards and criteria for chemical dependence clinics are outlined in Title 14 NYCRR Part 822 and Title 18 NYCRR Section 505.27. The MMIS Provider Manual for Clinics also provides program guidance for claiming Medicaid reimbursement for chemical dependence services.

OBJECTIVE AND SCOPE

The objective of our audit was to ensure New York Service Network compliance with applicable federal and state laws, regulations, rules and policies governing the New York State Medicaid Program. With respect to outpatient chemical dependence services, our audit covered services paid by Medicaid from May 1, 2003 through December 31, 2007.

SUMMARY OF FINDINGS

We inspected a random sample of 100 services with $8,088.15 in Medicaid payments. Of the 100 services in our random sample, 98 services had at least one error and did not comply with state requirements. Of the 98 noncompliant services, most contained more than one deficiency. Specifics are as follows:

Error Description	Number of Errors
Incorrect Servicing Provider Number	85
Group Counseling Patient Limit Exceeded	11
Missing Progress Note	10
Excessive / Unapproved Visits	10
Duration of Group Visit Less Than Thirty Minutes	7
Missing Individual Treatment Plan	5
Missing Treatment Plan Review	5
Duration of Clinic Visit Less Than Thirty Minutes	5
Late Individual Treatment Plan	3
No Individual Counseling	2

Missing Signature on Progress Note	2
No Service Provided	1
Claims Submitted Over 90 Days from Date of Service	1
Missing Comprehensive Evaluation Update	1
Duration of Service Not Documented	1
Incorrect Rate Code Billed	1

Based on the procedures performed, the OMIG has determined New York Service Network was overpaid $7,548.94 in sample overpayments with an extrapolated point estimate of $2,589,991. The lower confidence limit of the amount overpaid is $2,183,945.

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INTRODUCTION

BACKGROUND

Medicaid Program

Pursuant to Title XIX of the Social Security Act, the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State governments jointly fund and administer the Medicaid program.

New York State's Medicaid Program

In New York State, the Department of Health (DOH) is the State agency responsible for operating the Medicaid program. Within DOH, the Office of Health Insurance Programs administers the Medicaid program. DOH uses the electronic Medicaid New York Information system (eMedNY), a computerized payment and information reporting system, to process and pay Medicaid claims, including outpatient chemical dependence services claims.

As part of this responsibility, the OMIG conducts audits and reviews of various providers of Medicaid reimbursable services, equipment and supplies. These audits and reviews are directed at ensuring provider compliance with applicable laws, regulations, rules and policies of the Medicaid program as set forth by the Departments of Health and Mental Hygiene [Titles 10, 14 and 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York] and the Medicaid Provider Manuals.

New York State's Outpatient Chemical Dependence Services Program

Outpatient chemical dependence services are provided in either hospital-based or free-standing settings. Regardless of the setting in which they are provided, these services must be furnished in one of two distinct programs: an outpatient chemical dependence clinic program or an outpatient chemical dependence rehabilitation program. The purpose of outpatient programs for individuals with a diagnosis of chemical dependence is to provide medical evaluation, clinical care management, clinical services, and rehabilitation services. The specific standards and criteria for chemical dependence clinics are outlined in Title 14 NYCRR Part 822 and Title 18 NYCRR Section 505.27. The MMIS Provider Manual for Clinics also provides program guidance for claiming Medicaid reimbursement for chemical dependence services.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

The objective of our audit was to ensure New York Service Network compliance with applicable Federal and State laws, regulations, rules and policies governing the New York State Medicaid Program and to verify that:

- Medicaid reimbursable services were rendered for the dates billed;
- appropriate rate or procedure codes were billed for services rendered;
- patient related records contained the documentation required by the regulations; and,

- claims for payment were submitted in accordance with DOH regulations and the appropriate Provider Manuals.

Scope

Our audit period covered payments to New York Service Network for outpatient chemical dependence services paid by Medicaid from May 1, 2003, through December 31, 2007. Our audit universe consisted of 63,355 claims totaling $4,996,162.80.

During our audit, we did not review the overall internal control structure of New York Service Network. Rather, we limited our internal control review to the objective of our audit.

Methodology

To accomplish our objective, we:

- reviewed applicable federal and state laws, regulations, rules and policies;
- held discussions with New York Service Network management personnel to gain an understanding of the outpatient chemical dependence services program;
- ran computer programming application of claims in our data warehouse that identified 63,355 paid outpatient chemical dependence services program claims, totaling $4,996,162.80;
- selected a random sample of 100 services from the population of 63,355 services; and,
- estimated the overpayment paid in the population of 63,355 services.

For each sample selection we inspected, as available, the following:

- Medicaid electronic claim information

- Patient records, including, but not limited to:
  - Progress Notes
  - Treatment Plans and Treatment Plan Reviews
  - Comprehensive Evaluations
  - Psychiatric Assessments
  - OASAS Level of Care Determinations
  - Group Attendance Records
  - Discharge Plans and Discharge Summaries

- Any additional documentation deemed necessary by OMIG to substantiate the Medicaid paid claim

LAWS, REGULATIONS, RULES AND POLICIES

The following are applicable Laws, Regulations, Rules, and Policies of the Medicaid program referenced when conducting this audit:

- Department of Health and Mental Hygiene [Titles 10, 14, and 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York (10 NYCRR, 14 NYCRR, 18 NYCRR)].

- Medicaid Management Information System and eMedNY Provider Manual.

- Specifically, 14 NYCRR Part 822

- In addition to any specific detailed findings, rules and/or regulations which may be listed below, the following regulations pertain to all audits:

  Regulations state: "By enrolling the provider agrees: (a) to prepare and to maintain contemporaneous records demonstrating its right to receive payment . . . and to keep for a period of six years from the date the care, services or supplies were furnished, all records necessary to disclose the nature and extent of services furnished and all information regarding claims for payment submitted by, or on behalf of, the provider . . . (e) to submit claims for payment only for services actually furnished and which were medically necessary or otherwise authorized under the Social Services Law when furnished and which were provided to eligible persons; (f) to submit claims on officially authorized claim forms in the manner specified by the department in conformance with the standards and procedures for claims submission; . . . (h) that the information provided in relation to any claim for payment shall be true, accurate and complete; and (i) to comply with the rules, regulations and official directives of the department." *18 NYCRR Section 504.3*

  Regulations state: "All bills for medical care, services and supplies shall contain: . . . (8) a dated certification by the provider that the care, services and supplies itemized have in fact been furnished; that the amounts listed are due and owing . . .; that such records as are necessary to disclose fully the extent of care, services and supplies provided to individuals under the New York State Medicaid program will be kept for a period of not less than six years from the date of payment . . .; and that the provider understands that payment and satisfaction of this claim will be from Federal, State and local public funds and that he or she may be prosecuted under applicable Federal and State laws for any false claims, statements or documents, or concealment of a material fact provided. . . ."

  18 NYCRR Section 540.7(a)

  Regulations state: "An overpayment includes any amount not authorized to be paid under the medical assistance program, whether paid as the result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse or mistake." *18 NYCRR Section 518.1(c)*

Furthermore, according to regulations, all providers must prepare and maintain contemporaneous records demonstrating their right to receive payment under the medical assistance program. In addition, the provider must keep, for a period of six years, all records necessary to disclose the nature and extent of services furnished and the medical necessity therefore, including any prescription or fiscal order for the service or supply. This information is subject to audit for a period of six years and must be furnished, upon request.

18 NYCRR Section 517.3(b)

DETAILED FINDINGS

The OMIG's review of Medicaid claims paid to New York Service Network from May 1, 2003 to December 31, 2007 identified 98 claims with at least one error, for a total sample overpayment of $7,548.94 (Attachment C).

Sample Selection

1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 23, 24, 26, 28, 29, 30, 31, 32, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 48, 49, 52, 53, 54, 55, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 70, 72, 73, 74, 75, 76, 77, 79, 80, 81, 82, 83, 84, 85, 86, 87, 89, 90, 91, 94, 96, 97, 98, 99, 100

1. Incorrect Service Provider Number

Regulations state, "By enrolling the provider agrees . . . that the information provided in relation to any claim for payment shall be true, accurate and complete; and . . . to comply with the rules, regulations and official directives of the department."

18 NYCRR Section 504.3(h)(i)

The June 2002 Medicaid Update states that the Office of Medicaid Management activated a series of edits that require identification of servicing and referring practitioners. These edits verify that the practitioner's license or MMIS provider ID numbers repaired on clinic claims are accurate and legitimate.

Medicaid Update, June 2002, Volume 17, Number 6, Page 3

In 85 instances pertaining to 78 patients, the servicing provider was not accurately identified. The servicing practitioner's name on the claim did not match the name of the practitioner who signed the medical entry.

		Sample Selection
2.	**Group Counseling Patient Limit Exceeded** **For Services Prior to 12/27/2006:** Regulations state, "Each outpatient service must directly provide the following: group counseling (containing no more than 15 persons) and individual counseling. *14 NYCRR Section 822.2(c)(1)* **For Services 12/27/2006 and After:** Regulations state, "Each outpatient service must directly provide the following: group counseling (containing no more than 15 persons)." *14 NYCRR Section 822.2(c)(2)* In 11 instances pertaining to 11 patients, the maximum number of patients allowed for group counseling services was exceeded.	38, 75, 76, 77, 79, 80, 81, 82, 83, 87, 89
3.	**Missing Progress Note** **For Services Prior to 12/27/06:** Regulations state, "Progress notes shall be written at least every five visits or twice per month, whichever comes first, unless the patient is scheduled less frequently than twice per month, in which case a progress note shall be written after every session." *14 NYCRR Section 822.4(s)* **For Service 12/27/06 and After:** Regulations state, "Progress notes shall be written at least every five visits or twice per month, whichever comes first, unless the patient is scheduled less frequently than twice per month, in which case a progress note shall be written after each session." *14 NYCRR Section 822.4(s)* In 10 instances pertaining to 10 patients, there was no progress note that related to the services billed.	22, 27, 33, 47, 50, 51, 78, 88, 92, 93

		Sample Selection
4.	**Excessive / Unapproved Visits** Regulations state, "Treatment according to the plan. The responsible clinical staff member shall ensure that the plan is included in the patient's record and that all treatment is provided in accordance with the treatment plan." *18 NYCRR Section 822.4(m)* Regulations state, "The treatment plan shall: include schedules for the provision of all services prescribed to the patient and their significant other as appropriate..." *18 NYCRR Section 822.4(l)(6)* In 10 instances pertaining to 10 patients, the maximum number of services allowed by the treatment plan was exceeded.	17, 23, 38, 41, 42, 65, 68, 84, 87, 92
5.	**Duration of Group Visit Less Than Thirty Minutes** **For Services Prior to 12/27/2006:** Regulations state, "There shall be reimbursement only for visits that meet the following requirements: . . . each occasion of service must last at least 30 minutes." *14 NYCRR Section 822.10(e)(3)* **For Services 12/27/2006 and After:** Regulations state, "There shall be reimbursement only for visits that meet the following requirements:. . . each occasion of service must last at least 30 minutes." *14 NYCRR Section 822.11(e)(3)* In 7 instances pertaining to 7 patients, the duration of the group visit was less than thirty minutes. The group visit was disallowed.	5, 13, 26, 52, 53, 55, 98

Sample Selection

6. Missing Individual Treatment Plan — 16, 28, 48, 54, 56

For Services Prior to 12/27/2006:

Regulations state, "Within thirty days of admission to an outpatient service, a written individual treatment plan based on the comprehensive evaluation shall be developed and approved by the multidisciplinary team for each patient."

14 NYCRR Section 822.4(f)

For Services 12/27/2006 and After:

Regulations state, "Within thirty days of admission to an outpatient service, a written individual treatment plan (the treatment plan) for each patient based on the comprehensive evaluation shall be developed by the primary counselor or the primary therapist and reviewed and approved by the multidisciplinary team."

14 NYCRR Section 822.4(f)

Regulations also state the minimum documentation requirements of the individual treatment plan for each person admitted for outpatient treatment services.

14 NYCRR Section 822.4(l)

In 5 instances pertaining to 5 patients, the required individual treatment plan was not completed.

7. Missing Treatment Plan Review — 34, 36, 56, 61, 78

Regulations state, "The entire treatment plan, once established, shall be thoroughly reviewed and revised at least every ninety calendar days thereafter. . . ."

14 NYCRR Section 822.4(n)

In 5 instances pertaining to 5 patients, the required treatment plan review was not completed.

		Sample Selection
8.	**Duration of Clinic Visit Less Than Thirty Minutes** **For Services Prior to 12/27/2006:** Regulations state, "There shall be reimbursement only for visits that meet the following requirements: . . . each occasion of service must last at least 30 minutes." *14 NYCRR Section 822.10(e)(3)* **For Services 12/27/2006 and After:** Regulations state, "There shall be reimbursement only for visits that meet the following requirements:. . . each occasion of service must last at least 30 minutes." *14 NYCRR Section 822.11(e)(3)* In 5 instances pertaining to 5 patients, the duration of the clinic visit was less than thirty minutes. The clinic visit was disallowed.	3, 8, 25, 32, 100
9.	**Late Individual Treatment Plan** **For Services Prior to 12/27/2006:** Regulations state, "Within thirty days of admission to an outpatient service, a written individual treatment plan based on the comprehensive evaluation shall be developed and approved by the multidisciplinary team for each patient." *14 NYCRR Section 822.4(f)* **For Services 12/27/06 and After:** Regulations state, "Within thirty days of admission to an outpatient service, a written individual treatment plan (the treatment plan) for each patient based on the comprehensive evaluation shall be developed by the primary counselor or the primary therapist and reviewed and approved by the multidisciplinary team." *14 NYCRR Section 822.4(f)* Regulations also state the minimum documentation requirements of the individual treatment plan for each person admitted for outpatient treatment services. *14 NYCRR Section 822.4(l)* In 3 instances pertaining to 3 patients, the individual treatment plan was late.	1, 31, 55

Sample Selection

10. No Individual Counseling — 67, 82

For Services 12/27/2006 and After:

Regulations state, "Each outpatient service must directly provide the following: (1) individual counseling (for each individual patient, at least one out of every ten counseling sessions must be an individual counseling session of at least one half hour in duration with the individual patient's primary counselor . . .)."

14 NYCRR Section 822.2(c)(1)

In 2 instances pertaining to 2 patients, the patient was not receiving an individual counseling service within every ten counseling sessions.

11. Missing Signature on Progress Note — 6, 56

Regulations state, "Progress notes shall be written, signed and dated by the clinical staff providing the service."

18 NYCRR Section 822.4(s)(1)

In 2 instances pertaining to 2 patients, the Progress note lacked the required approval as denoted by signatures of the multidisciplinary team and/or the signature of the responsible clinical staff member.

12. No Service Provided — 95

Regulations state, "All occasions of service provided during a visit must be documented in the patient's treatment record."

18 NYCRR Section 505.27(b)(5)

For Services Prior to 12/27/2006:

Furthermore, "The content and/or outcome of all visits must be fully documented in the individual patient or significant other's treatment record."

14 NYCRR Section 822.10(f)

In 1 instance, the patient record did not document that a service was provided.

Sample Selection

13. Claims Submitted More Than 90 Days After Date of Service — 47

Regulations state: "Claims for payment for medical care, services or supplies furnished by any provider under the medical assistance program must be initially submitted within 90 days of the date the medical care, services or supplies were furnished to an eligible person to be valid and enforceable against the department or a social services district, unless the provider's submission of the claims is delayed beyond 90 days due to circumstances outside of the control of the provider. Such circumstances include but are not limited to attempts to recover from a third-party insurer, legal proceedings against a responsible third-party or the recipient of the medical care, services or supplies or delays in the determination of client eligibility by the social services district. All claims submitted after 90 days must be accompanied by a statement of the reason for such delay and must be submitted within 30 days from the time submission came within the control of the provider, subject to the limitations of paragraph (3) of this subdivision."

18 NYCRR Section 540.6(a)(1)

The MMIS Provider Manual states: "Medicaid regulations require that claims for payment of medical care, services, or supplies to eligible enrollees be initially submitted within 90 days of the date of service to be valid and enforceable, unless the claim is delayed due to circumstances outside the control of the provider."

MMIS Provider Manual Information for All Providers General Billing, Page 6

In 1 instance, the claim was submitted more than 180 days after the date of service without the valid use of an exception code as the reason for the late submission of the claim. Regulations require a claim to be submitted within 90 days of the date of service; however, the OMIG disallowed claims submitted more than 180 days after the date of service without supporting documentation. This is in keeping with general industry standards.

Sample Selection

14. Missing Comprehensive Evaluation Update — 8

Regulations state, "Every fourth . . . ninety calendar day [treatment plan] review shall include an update of the comprehensive evaluation."

14 NYCRR Section 822.4(n)

In 1 instance, the comprehensive evaluation was not updated upon completion of the fourth ninety calendar day treatment plan review.

15. Duration of Visit Not Documented — 36

Regulations state, "An attendance note shall document the date, type and duration of the service provided."

14 NYCRR Section 822.4(r)

In 1 instance, the record did not indicate the duration of the visit. The clinic visit was disallowed.

16. Incorrect Rate Code Billed — 65

Regulations state, "Payment for chemical dependence services shall be at fees established by the Department of Health and approved by the Director of the Division of Budget as contained in the fee schedule for chemical dependence outpatient services."

18 NYCRR Section 505.27(d)(1)

In 1 instance, the incorrect rate code was billed which resulted in higher reimbursement than indicated in the fee schedule for the proper rate code.

PROVIDER RIGHTS

In accordance with *18 NYCRR Part 518* which regulates the collection of overpayments, your repayment options are described below. If you decide to repay the lower confidence limit amount of $2,183,945, one of the following repayment options must be selected within 20 days from the date of this letter:

OPTION #1: Make full payment by check or money order within 20 days of the date of the final report. The check should be made payable to the New York State Department of Health and be sent with the attached Remittance Advice to:

Mr. Donald Collins
New York State Department of Health
Medicaid Financial Management
GNARESP Corning Tower, Room 1237
Albany, New York 12237-0048

OPTION #2: Enter into a repayment agreement with the Office of the Medicaid Inspector General. If your repayment terms exceed 90 days from the date of the final report, recoveries of amounts due are subject to interest charges at the prime rate plus 2%. If the process of establishing the repayment agreement exceeds 20 days from the date of the final report, the OMIG will impose a 15% withhold after 20 days until the agreement is established.

Furthermore, the OMIG may require financial information from you to establish the terms of the repayment agreement. If additional information is requested, the OMIG must receive the information within 30 days of the request or a 50% withhold will be imposed. OMIG acceptance of the repayment agreement is based on your repaying the Medicaid overpayment as agreed. The OMIG will adjust the rate of recovery, or require payment in full, if your unpaid balance is not being repaid as agreed. The OMIG will notify you no later than 5 days after initiating such action. If you wish to enter into a repayment agreement, you must forward your written request within 20 days to the following:

Bureau of Collections Management
New York State Office of the Medicaid Inspector General
800 North Pearl Street
Albany, New York 12204
Phone #: (518) 474-5878
Fax#: (518) 408-0593

If within 20 days, you fail to make full payment or contact the OMIG to make repayment arrangements, the OMIG will establish a withhold equal to 50% of your Medicaid billings to recover payment and liquidate the lower confidence limit amount, interest and/or penalty, not barring any other remedy allowed by law. The OMIG will provide notice to you no later than 5 days after the withholding of any funds. In addition, if you receive an adjustment in your favor while you owe funds to the State, such adjustment will be applied against the amount owed.

If you choose not to settle this audit through repayment of the adjusted lower confidence limit, you have the right to challenge these findings by requesting an administrative hearing where the OMIG would seek and defend the point estimate of $2,589,991. As allowed by state regulations, you must make your request for a hearing, in writing, within sixty (60) days of the date of this report to:

General Counsel
Office of Counsel
New York State Office of the Medicaid Inspector General
800 North Pearl Street
Albany, New York 12204

Questions regarding the request for a hearing should be directed to Charlene D. Fleszar, Esq., Office of Counsel, at (518) 408-5811.

Issues you may raise shall be limited to those issues relating to determinations contained in the final audit report. Your hearing request may not address issues regarding the methodology used to determine the rate, or any issue that was raised at a proceeding to appeal a rate determination.

At the hearing you have the right to:

a) be represented by an attorney or other representative, or to represent yourself;
b) present witnesses and written and/or oral evidence to explain why the action taken is wrong; and
c) cross examine witnesses of the Department of Health and/or the OMIG.

The OMIG reserves the right to conduct further reviews of your participation in the Medicaid Program, take action where appropriate, and recover monies owed through the initiation of a civil lawsuit or other legal mechanisms including but not limited to the recovery of state tax refunds pursuant to Section 206 of the Public Health Law and Section 171-f of the State Tax Law.

NEW YORK STATE
OFFICE OF THE MEDICAID INSPECTOR GENERAL
REMITTANCE ADVICE

NAME AND ADDRESS OF AUDITEE
Fred Middleton
Executive Director
New York Service Network, Inc.
198 Foster Ave
Brooklyn, NY 11230

AMOUNT DUE: $2,183,945

PROVIDER ID #02265429

AUDIT #09-2553

AUDIT TYPE
[X] PROVIDER
[ ] RATE
[ ] PART B
[ ] OTHER:

CHECKLIST

1. To ensure proper credit, please enclose this form with your check.
2. Make checks payable to: *New York State Department of Health*
3. Record the Audit Number on your check.
4. Mail check to:

Mr. Donald Collins
New York State Department of Health
Medicaid Financial Management, B.A.M.
GNARESP Corning Tower, Room 1237
File #09-2553
Albany, New York 12237-0048

Thank you for your cooperation.

Attachment "A"

SAMPLE DESIGN AND METHODOLOGY

Our sample design and methodology are as follows:

- Universe - Medicaid claims for outpatient chemical dependence services paid during the period May 1, 2003, through December 31, 2007.

- Sampling Frame - The sampling frame for this objective is the Medicaid electronic database of paid New York Service Network claims for outpatient chemical dependence services paid during the period May 1, 2003, through December 31, 2007.

- Sample Unit - The sample unit is a Medicaid claim paid during the period May 1, 2003, through December 31, 2007

- Sample Design – Simple sampling was used for sample selection.

- Sample Size – The sample size is 100 services.

- Source of Random Numbers – The source of the random numbers was the OMIG statistical software. We used a random number generator for selecting our random sampling items.

- Characteristics to be measured - Adequacy of documentation received supporting the sample claims.

- Treatment of Missing Sample Services - For purposes of appraising items, any sample service for which New York Service Network could not produce sufficient supporting documentation was treated as an error.

- Estimation Methodology – Estimates are based on the sample data using per unit estimates.

Attachment "B"

SAMPLE RESULTS AND ESTIMATES

		Non-Projected*
Universe Size	63,355	
Sample Size	100	
Sample Book Value	$8,088.15	
Sample Overpayments	$7,548.94	$3,466.35
Net Financial Error Rate	93.3%	
Mean Dollars in Error	$40.8259	
Standard Deviation	38.64	
Point Estimate of Total Dollars	$2,589,991	$3,466
Confidence Level	90%	
Lower Confidence Limit	$2,183,945	$3,466

**The Point Estimate of Total Dollars* and *the Lower Confidence Limit* both contain $3,466 in non-projected overpayments.

OFFICE OF THE MEDICAID INSPECTOR GENERAL
NEW YORK SERVICE NETWORK, INC.
REVIEW OF SAMPLE SELECTION
PROJECT NUMBER: 09-2553
REVIEW PERIOD: 5/1/03 - 12/31/07

Sample Number	CIN #	Patient Name	Date of Service	Rate Code Billed	Rate Code Derived	Amount Billed	Amount Derived	Overpayment Projected	Overpayment Not Projected	DETAILED FINDINGS 1. Incorrect Servicing Provider Number	2. Group Counseling Patient Limit Exceeded	3. Missing Progress Note	4. Excessive / Unapproved Visits	5. Duration of Group Visit Less Than Thirty Minutes	Other Findings
1			04/14/05	4216		$ 77.03	$ -	$ 77.03	$ -	X					9
2			04/22/05	4216		77.03	-	-	77.03	X					
3			04/26/05	4215		77.03	-	77.03	-	X					8
4			05/05/05	4216		77.03	-	-	77.03	X					
5			05/12/05	4216		77.03	-	77.03	-	X				X	
6			06/01/05	4216		77.03	-	77.03	-	X					11
7			05/16/05	4216		77.03	-	-	77.03	X					
8			05/23/05	4215		77.03	-	77.03	-	X					8, 14
9			05/19/05	4216		77.03	-	-	77.03	X					
10			07/05/05	4216		77.03	-	-	77.03	X					
11			06/30/05	4216		77.03	-	-	77.03	X					
12			08/11/05	4215		77.03	-	-	77.03	X					
13			08/10/05	4216		77.03	-	77.03	-	X				X	
14			09/06/05	4216		77.03	-	-	77.03	X					
15			10/10/05	4214		77.03	-	-	77.03	X					
16			10/26/05	4216		77.03	-	77.03	-	X					6
17			11/11/05	4216		77.03	-	77.03	-	X			X		
18			11/08/05	4216		77.03	-	-	77.03	X					
19			01/05/06	4215		77.03	-	-	77.03	X					
20			02/07/06	4216		77.03	-	-	77.03	X					
21			09/16/05	4215		77.03	-	-	77.03	X					
22			03/17/06	4216		77.03	-	77.03	-			X			
23			03/23/06	4216		77.03	-	77.03	-	X			X		
24			03/27/06	4215		77.03	-	-	77.03	X					
25			03/02/06	4215		77.03	-	77.03	-						8

OFFICE OF THE MEDICAID INSPECTOR GENERAL
NEW YORK SERVICE NETWORK, INC.
REVIEW OF SAMPLE SELECTION
PROJECT NUMBER: 09-2553
REVIEW PERIOD: 5/1/03 - 12/31/07

Sample Number	CIN #	Patient Name	Date of Service	Rate Code Billed	Rate Code Derived	Amount Billed	Amount Derived	Overpayment Projected	Overpayment Not Projected	DETAILED FINDINGS 1. Incorrect Servicing Provider Number	2. Group Counseling Patient Limit Exceeded	3. Missing Progress Note	4. Excessive / Unapproved Visits	5. Duration of Group Visit Less Than Thirty Minutes	Other Findings
26			04/28/06	4216		$ 77.03	$ -	$ 77.03	$ -	X				X	
27			05/05/06	4215		77.03	-	77.03	-			X			
28			05/05/06	4215		77.03	-	77.03	-	X					6
29			05/19/06	4215		77.03	-	-	77.03	X					
30			05/26/06	4215		77.03	-	-	77.03	X					
31			06/08/06	4216		77.03	-	77.03	-	X					9
32			06/08/06	4215		77.03	-	77.03	-	X					8
33			06/16/06	4215		77.03	-	77.03	-			X			
34			06/21/06	4216		77.03	-	77.03	-	X					7
35			07/05/06	4216		77.03	-	-	77.03	X					
36			07/13/06	4215		77.03	-	77.03	-	X					7, 15
37			07/31/06	4215		77.03	-		77.03	X					
38			08/12/06	4216		77.03	-	77.03	-	X	X		X		
39			09/19/06	4216		77.03	-	-	77.03	X					
40			10/04/06	4216		77.03	-	-	77.03	X					
41			10/18/06	4215		77.03	-	77.03	-	X			X		
42			11/02/06	4216		77.03	-	77 03	-	X			X		
43			12/14/06	4216		77.03	-	-	77.03	X					
44			01/16/07	4216		77.03	-	-	77.03	X					
45			01/22/07	4216		77.03	-	-	77.03	X					
46			02/05/07	4215		77.03	-	-	77.03	X					
47			07/19/06	4216		77.03	-	77.03	-			X			13
48			03/24/07	4216		77.03	-	77.03	-	X					6
49			02/06/07	4216		77.03	-	-	77.03	X					
50			03/30/07	4215		77.03	-	77.03	-			X			

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Sample Number	CIN #	Patient Name	Date of Service	Rate Code Billed	Rate Code Derived	Amount Billed	Amount Derived	Overpayment Projected	Overpayment Not Projected	DETAILED FINDINGS 1. Incorrect Servicing Provider Number	2. Group Counseling Patient Limit Exceeded	3. Missing Progress Note	4. Excessive / Unapproved Visits	5. Duration of Group Visit Less Than Thirty Minutes	Other Findings
51			04/11/07	4215		$ 77.03	$ -	$ 77.03	$ -			X			
52			04/12/07	4216		77.03	-	77.03	-	X				X	
53			04/18/07	4216		77.03	-	77.03	-	X				X	
54			04/19/07	4216		77.03	-	77.03	-	X					6
55			04/16/07	4216		77.03	-	77.03	-	X				X	9
56			05/07/07	4216		77.03	-	77.03	-						6, 7, 11
57			05/25/07	4216		77.03	-	-	77.03	X					
58			06/15/07	4216		77.03	-	-	77.03	X					
59			06/15/07	4216		77.03	-	-	77.03	X					
60			06/19/07	4216		77.03	-	-	77.03	X					
61			07/18/07	4216		77.03	-	77.03	-	X					7
62			07/30/07	4215		77.03	-	-	77.03	X					
63			08/30/07	4216		77.03	-	-	77.03	X					
64			08/31/07	4215		77.03	-	-	77.03	X					
65			09/12/07	4215		77.03	-	77.03	-	X			X		16
66			09/27/07	4216		77.03	-	-	77.03	X					
67			10/13/07	4216		77.03	-	77.03	-	X					10
68			10/06/07	4216		77.03	-	77.03	-	X			X		
69			11/13/07	4216	4216	231.09	231.09	-	-						
70			10/24/07	4215		77.03	-	-	77.03	X					
71			11/23/07	4216	4216	308.12	308.12	-	-						
72			12/03/07	4216		77.03	-	-	77.03	X					
73			12/05/07	4215		77.03	-	-	77.03	X					
74			12/11/07	4214		77.03	-	-	77.03	X					
75			04/29/03	4216		77.03	-	77.03	-	X	X				

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Sample Number	CIN #	Patient Name	Date of Service	Rate Code Billed	Rate Code Derived	Amount Billed	Amount Derived	Overpayment Projected	Overpayment Not Projected	DETAILED FINDINGS 1. Incorrect Servicing Provider Number	2. Group Counseling Patient Limit Exceeded	3. Missing Progress Note	4. Excessive / Unapproved Visits	5. Duration of Group Visit Less Than Thirty Minutes	Other Findings
76			04/30/03	4216		$ 77.03	$ -	$ 77.03	$ -	X	X				
77			05/16/03	4216		77.03	-	77.03	-	X	X				
78			06/09/03	4216		77.03	-	77.03	-			X			7
79			06/18/03	4216		77.03	-	77.03	-	X	X				
80			06/25/03	4216		77.03	-	77.03	-	X	X				
81			08/05/03	4216		77.03	-	77.03	-	X	X				
82			07/18/03	4216		77.03	-	77.03	-	X	X				10
83			10/30/03	4215		77.03	-	77.03	-	X	X				
84			11/07/03	4215		77.03	-	77.03	-	X			X		
85			12/24/03	4216		77.03	-	-	77.03	X					
86			01/06/04	4215		77.03	-	-	77.03	X					
87			01/06/04	4216		77.03	-	77.03	-	X	X		X		
88			01/12/04	4215		77.03	-	77.03	-			X			
89			04/05/04	4216		77.03	-	77.03	-	X	X				
90			04/07/04	4216		77.03	-	-	77.03	X					
91			04/20/04	4216		77.03	-	-	77.03	X					
92			04/30/04	4215		77.03	-	77.03	-			X	X		
93			06/10/04	4216		77.03	-	77.03	-			X			
94			05/12/04	4216		77.03	-	-	77.03	X					
95			06/02/04	4216		77.03	-	77.03	-						12
96			07/21/04	4216		77.03	-	-	77.03	X					
97			10/22/04	4216		77.03	-	-	77.03	X					
98			11/19/04	4216		77.03	-	77.03	-	X				X	
99			12/01/04	4215		77.03	-	-	77.03	X					
100			03/02/05	4216		77.03	-	77.03	-	X					8
Total						$ 8,088.15	$ 539.21	$ 4,082.59	$ 3,466.35	85	11	10	10	7	27

OFFICE OF THE MEDICAID INSPECTOR GENERAL
NEW YORK SERVICE NETWORK, INC.
REVIEW OF SAMPLE SELECTION
PROJECT NUMBER: 09-2553
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Legend of Category "OTHER FINDINGS"

6	Missing Individual Treatment Plan
7	Missing Treatment Plan Review
8	Duration of Clinic Visit Less Than Thirty Minutes
9	Late Individual Treatment Plan
10	No Individual Counseling
11	Missing Signature on Progress Note
12	No Service Provided
13	Claims Submitted Over 90 Days from Date of Service
14	Missing Comprehensive Evaluation Update
15	Duration of Visit Not Documented
16	Incorrect Rate Code Billed